Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
18 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Months)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	Head Circ. (cm)	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Whole Milk [ ] Cup [ ] Table Foods
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT **Age appropriate?** [ ] Yes [ ] No
15 to 20 words, some two word phrases, runs stiffly, walks backwards, throws a ball, uses spoon and cup.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Discipline/limits
[ ] Good parenting practices
[ ] Sleep practices
[ ] Sibling interaction
[ ] Mealtimes
[ ] Toilet training
[ ] Read to child

REFERRALS

[ ] Dental
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No